DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accepted 9/30/08

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297049	A. BUILDING _____ B. WING _____	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERIVCES	245 EAST LIBERTY STREET, SUITE 100 RENO, NV 89504

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G 000	INITIAL COMMENTS A Medicare recertification survey was conducted at your agency from August 18-August 26, 2008. All conditions were met. Seven home visits were conducted and seventeen record reviews were conducted. The findings and conclusions of any investigation by the health division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	G 000	RECEIVED SEP 11 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements. This STANDARD is not met as evidenced by: Based on review of the agency's documentation and interview, the agency failed to have the correct Home Health Agency hotline number in their admission packets for patients. Findings include:	G 116	G 116 The agency will ensure that the patient is advised of the availability of the toll-free HHA hotline in the state. The agency will provide all current clients will the correct hotline number by no later than October 15, 2008. The agency will provide all new clients with the correct hotline number at time of admission. The administrator will educate all staff responsible for client admission in regards to necessity of hotline numbers and clients' acknowledgement of receipt and understanding of same. Administrator and/or delegated responsible staff will maintain compliance through monthly QA process. 11/02/2008	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bobbie Labrum, Docs, Administrator		9/10/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 116	Continued From page 1 Review of the admission packet revealed that the agency had the State agency's number on the admission packet and not the Home Health Agency hotline number. Interview with Patient #7 revealed that the patient was unaware of the agency's hotline number nor was the patient aware of when it was to be utilized.	G 116		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review and observation the agency failed to assure that services were coordinated and a re-evaluations were being done to meet the patients' dietary needs for 2 of 17 patients. (Patient #5 and #8). Findings include: Patient #5's record review and observation revealed a 9 year old male with a diagnosis of quadriplegia. He received enteral feedings through a gastrotomy tube. When the staff were asked how the enteral feedings were assessed to assure that he was receiving adequate calories for growth and nutrition, the pediatric nurse who coordinates the care of pediatric patients at the agency was unsure. After some research during the survey it was apparent that the dietary assessments were done by the company who	G 143	G 143 The agency will ensure that all services are coordinated and re-evaluated to meet the clients' needs to include but not limited to dietary needs. The Administrator will educate all staff responsible for coordination of care regarding the necessity of dietary consultation and necessary follow-up assessment/coordination of care at time of admission and PRN per individual client need on or before October 2, 2008. Administrator or qualified designee will monitor compliance through the case conference and QA process ongoing. 11/02/2008 Review will occur quarterly 9/30/08	

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G 143	Continued From page 2 supplies the feedings to the home. A new company had taken over three weeks prior to the exit date of the survey. Contact with that company's dietitian was done and documentation was requested. The documentation revealed that they had not received the original assessment from the previous company. Patient #8's record review and observation revealed a 13 year female with a diagnosis of asphyxiation with strangulation and gastrotomy. According to the plan of care she was receiving Elecare with Pedialyte 70 milliliters (ml) per hour for 22 hours via a JT mic-key button. Additional nutritional orders included 200 ml of water with 300 ml cranberry juice (500 ml total) solution at 70ml/hour give per J-button two times a week. When the staff were asked how the enteral feedings were assessed to assure that she was receiving adequate calories for growth and nutrition, the pediatric nurse who coordinates the care of pediatric patients at the agency was unsure. After some research during the survey it was apparent that the dietary assessments were done by the company who supplies the feedings to the home. A new company had taken over three weeks prior to the exit date of the survey. Contact with that company's dietitian was done and documentation was requested. The documentation revealed that they had not received the original assessment from the previous company.	G 143		
G 163	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when	G 163	G 163 The agency will ensure that the total plan of care is reviewed by the attending physician at least every 60 days, and PRN as the client condition requires. The Administrator will educate the Internal Clinical Staff regarding the use of the INFOMAX	

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G 163	Continued From page 3 there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to have a system in place to conduct their 60 day recertifications in a timely manner for 4 of 17 patients (Patient #5, #8, #9, and #12). Findings include: Patient #5's record review on 8/18/08 revealed a start of care on 4/19/07. The last recertification period was 6/12/08 to 8/10/08. The current recertifcation plan of care was being assimilated. When the Director of Clinical Services and nurse responsible for the plan of care were interviewed both confirmed the current plan of care was not completed and had not been sent to the physician. Patient #8's record review on 8/19/08 revealed a start of care on 11/01/05. The last recertification period was 6/20/08 to 8/18/08. When asked for the current plan of care the director stated it had just been entered into the computer. No evidence was given that it had been sent to the physician. Patient #9's record review on 8/19/08 revealed a start of care of 10/31/05. The last recertification period documented was 6/5/08 to 8/03/08. No	G 163	system related to the tracking of client requirement as it pertains to the timely completion the 60 day assessment and plan of care. The Administrator and Internal Clinical Staff will ensure that all plans of care are completed and sent to the physician at least every 60 days. The Administrator will ensure compliance by monitoring the INFOMAX requirement and orders tracking programs on at least a weekly basis. 11/02/2008	

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G 163	Continued From page 4 current plan of care was available on 8/19/08 for the present plan of care. This was confirmed by the Director of Clinical Services. Patient #12's record revealed a start of care date of 6/15/08 with a certification period from 6/15/08 through 8/13/08. The physician signature was dated 7/15/08. Review of the medical record revealed there was no current plan of care and updated physician orders completed prior to the end of the certification period. Interview with the Director of Clinical Services on 8/20/08 confirmed the re-certification assessment and updated plan of care was missed. The Director indicated that the physical therapist conducted the final assessment of the patient's functional status and recommended discharge as the client no longer needed therapy services as of 8/13/08.	G 163		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to establish a system for obtaining physician signatures on current drug and treatment orders in a timely manner for 4 of 17 patients. (Patients #1, #3, #7, #13) and failed to include all medications on plans of care for physician signatures for 1 of 17 patients (Patient # 17). Findings include: Per Nevada Administrative Code 449.800 (2). Initial medical orders, renewals and changes of	G 165	G 165 The agency will ensure that all initial medical orders, renewals and changes of orders for skilled and other therapeutic services are submitted by telephone and are recorded before they are carried out. The administrator will educate all internal and external nursing and therapy staff regarding the necessity of this process in maintaining compliance with G 165 as well as the NAC 449.800 (2).External staff providing skilled and/or therapy services will be responsible for obtaining and documenting verbal orders for any changes in the client plan of care, verification of said orders, and will be responsible for forwarding any change in orders to the Administrator or Internal Clinical Nursing Staff within 24 hours of receipt of said verbal orders	

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G 165	Continued From page 5 orders for skilled nursing and other therapeutic services submitted by telephone must be recorded before they are carried out. All medical orders must bear the signature of the physician who initiated the order within 20 working days after the receipt of the oral order. Patient #1's record revealed a start of care date of 2/6/08 with a certification period through 4/5/08. The physician signature on the medical orders was dated 4/9/08. The home health agency services for the patient were for skilled nursing to administer Solumedrol intravenous times three days. The physician's signature on the discharge summary was also dated 4/9/08. Patient #3's record revealed a start of care date of 4/18/08 with a certification period through 6/16/08. The physician signature on the medical orders was dated 6/25/08. Per interview with the Director of Clinical Services, the patient was discharged on 4/30/08. Patient #7's record revealed a start of care date of 3/3/08. The plan of care recertification period was 7/1/08 to 8/29/08. The physician had not signed the orders until 8/29/08. Patient #13's record revealed a start of care date of 4/28/08 with a certification period through 6/26/08. The physician signature on the medical orders was dated 7/29/08. The next certification period was 6/27/08 to 8/25/08. The physician signature on the medical orders was dated 8/7/08. Patient #17's record revealed that the current plan of care dated 8/19/08 through 10/17/2008 did not contain the current list of medications that the	G 165	.Internal nursing staff will be responsible for forwarding orders to the physician within 24 hours of receipt of same, to the physician for signature or approval. Administrator and/or qualified designee will track orders to ensure compliance with 20 day signature date required by the NAC. Administrator will review at least weekly through the QA process. 11/02/2008	

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G 165	Continued From page 6 patient was receiving. Seroquel 50 mg orally at noon and Seroquel 50 mg at bedtime was not included on the current plan of care sent to the physician. Interview with the director of clinical services confirmed this was not included. It was noted that the patient was receiving the medication per documentation and per review at the home visit.	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to conduct an assessment for 2 of 17 patients to assure that the patients nursing needs were met. (Patients #6 and #16) Findings include: Patient #6's record review revealed a start of care date with the agency of 6/26/08. The patient was described in the plan of care as having "severe lung dysfunction due to emphysema, chronic obstructive lung disease due to A1 protein inhibitor deficiency and heavy cigarette smoking." It was stated he had lost 40 pounds in the last year. Skilled nursing visits were to assess his weight every week. On 6/26/08 it was documented that he weighed 147 pounds. On 8/6/08 his weight was documented as 168 pounds. Although his ideal body weight was documented to be 180 pounds and he was on a regular high calorie diet, there was no documentation that his weight gain of 21 pounds in two months had been assessed by the nurse to	G 172	G 172 The Agency will ensure that the registered nurse regularly re-evaluates the patients nursing needs, to include but not limited to the client dietary needs and current weight. The administrator will educate all nursing staff responsible for admission and/or on-going assessment regarding the assessment of the dietary needs and weight of all current patients. The administrator and/or qualified designee will monitor compliance through the QA process and case conference review/discussion at least every 60 days and PRN per client need. 11/02/2008	

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G 172	Continued From page 7 assure if this was appropriate. During the second interview with the Director of Clinical Services regarding the weight gain, she stated that when she had brought this to the nurses attention after the first interview the nurse agreed some assessment of this rapid weight gain should have been done. Patient #16's record review revealed that the start of care was 2/19/08. The current plan of care documented the goal "Clients weight will remain stable as evidence by no weight loss/gain greater that 5 pounds as evidenced by monthly weights X 60 days." The patient was receiving Jevity three times per day tube feedings. The patient was considered a high nutritional risk. The agency's documentation did not demonstrate monthly weights being assessed. There was a weight documented on 2/19/08 of 110 pounds. There were no other documented weights. When the Director of Clinical Services was asked how the patient was weighed since she was in a wheelchair, she was unsure. Although she did state she thought that "Trinity services" may have a chair scale.	G 172		
G 251	484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care. This STANDARD is not met as evidenced by: Based on documentation review and interview, the agency did not conduct a review of the clinical records for each 60 day period for adequacy of the plans of care.	G 251	G251 The agency will conduct review of the clinical record of each client for each 60 day period for adequacy of the plan of care. The Administrator will ensure that the QA committee meeting is held at least once per quarter to review active and discharged files for adequacy of plan of care. Finding will be brought forward to the professional advisory board for recommendations at least annually. The QA team will identify trends reportable to the Regional Director of Clinical Services for review and recommendation at least quarterly. 11/02/2008	

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G 251	Continued From page 8 Findings included: Review of the documentation provided revealed that the agency had conducted reviews until the fourth quarter of 2007. In the fourth quarter (October, November and December) of 2007, the agency did the review but not all disciplines participated. The Director of Clinical Services was the only professional that conducted the review. It was noted that patterns of the clinical record revew were brought forward to the professional advisory committee from this review. In the first quarter (January, February, and March) of 2008, the Director of Clinical Service and the occupational therapist participated in the reviews but not a physical therapist, speech therapist or social worker. No patterns or trends were brought forward. In the second quarter (April, May and June) of 2008 the quarterly review was not completed. Interview with the Director of Clinical services confirmed the above information.	G 251		